PROPOSED AMENDED RULE 106 NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS

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Section 1. Authority

This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-61-108(a)(1) and by Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules necessary for the effective regulation of the business of insurance and as required for this State to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR § 156.230 which require that Qualified Health Plans provide sufficiently accessible medical providers. In addition, this Rule is issued pursuant to the authority granted the Commissioner to issue regulations related to the provision of adequate health care services by health maintenance organizations under Ark. Code Ann. § 23-76-108(a).

Section 2. Purpose

The purpose of this Rule is to establish <u>minimum</u> standards for the creation and maintenance of networks by Health Carriers and to assure the adequacy, accessibility and quality of Health Care Services offered under Health Benefit Plans.

Section 3. Definitions

For purposes of this Rule:

- ——A. "Accredited Health Carrier" means a Health Carrier which has an adequate network as certified by an approved accrediting organization under the provisions of Section five (5)-(K) of this Rule.
- B. "Commissioner" means the Arkansas Insurance Commissioner.
- C. "Covered Benefits" or "benefits" means those Health Care Services to which a Covered Person is entitled under the terms of a Health Benefit Plan.
- D. "Covered Person" means a policyholder, subscriber, enrollee or other individual participating in a Health Benefit Plan.
- E. "Dental Benefits" means benefits for dental services embedded in, or offered by a rider attached to, (i) a QHP offered through the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.
- F. "Emergency Medical Condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
- F. "Emergency Services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

G

- HG. "Essential Community Provider" means a provider that serves predominantly low income, medically underserved individuals as defined in 45 C.F.R. §156.235.
- HI. "Facility" means an institution providing Health Care Services or a health are setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- ——_________________ "Health Benefit Plan" means any individual, blanket, or group plan, policy or contract for Health Care Services issued or renewed by a

Health Carrier on or after January 1, 2015 which requires a Covered Person to use Health Care Providers managed, owned, under contract with or employed by the Health Carrier. "Health Benefit Plan" does not include a plan providing Health Care Services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq., nor include an accident-only, specified disease, hospital indemnity, long-term care, disability income, or limited-benefit health insurance policy. The provisions of this Rule also do not apply to Medicare Supplement or Medicare Advantage policies. This Rule applies to Dental Benefits as defined in Section (3)(E) and Vision Benefits as defined in Section three (3)(Y), as well as plans offered by Stand-alone Dental Carriers as defined in Section three (3)(V) of this rule. This Rule does not apply to vision or dental only plans unless such plans are offered by Stand-alone Dental Carriers as defined in Section three (3) (U) of this Rule.

- JK. "Health Care Professional" means a physician or other Health Care practitioner licensed, accredited or certified to perform physical, behavioral, mental health or substance use disorder and health services consistent with state law.
- **KL**. "Health Care Provider" or "provider" means a participating Health Care or dental professional or a facility.
- <u>LM</u>. "Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- "Health Carrier" means an entity subject to the insurance laws and MN.regulations of this State, or subject to the jurisdiction of the Commissioner, which contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of Health Care Services, including a health insurer, a health maintenance organization, a hospital and medical services corporation, or any other entity providing Health Benefit Plan A Health Carrier does not include an automobile insurer paying medical or hospital benefits under Ark. Code Ann. §23-89-202(1) nor shall it include a self-insured employer Health Benefits Plan. A Health Carrier does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State providing medical or hospital benefits for accidental injury or accidental disability. A Health Carrier shall include an entity that provides Dental and/or Vision Benefits as defined in Section three (3)(E) and Section three (3)(Y) of this rule, respectively, or is not include a vision or dental insurer unless it is a

Stand-alone Dental Carrier as defined by Section three (3)- $(\underline{V}\underline{U})$ of this Rule.

- O.N. "Network" means the <u>collectiongroup</u> of <u>all</u> participating providers providing services to a Health Benefit Plan. The <u>network associated with a health benefit plan should be identifiable using a suitable network ID, and one Health Benefit Plan can have only one such network ID.</u>
- OP. "Provider" means a provider who, under a contract with a Health Carrier or with its contractor or subcontractor, has agreed to provide Health Care Services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the Health Carrier.
- PQ. "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH supports patients to connect with other Providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care.
- RQ. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- RS. "Primary Care Professional" means a participating Health Care Professional practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person.
- S. "Qualified Health Plan" means an insurance policy that meets the requirements of 42 U.S.C. §18021(a)(1).
- "Specialty Care Professional" means a participating Health Care Professional that is specialty qualified to practice by having attended an advanced program of study, passed an examination given by an organization of the members of the specialty, or gained experience through extensive practice in the specialty.

- V.U. "Stand-alone Dental Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, which (i) offers plans through ACA approved Marketplace and/or (ii) offers plans outside the ACA Marketplace for the purpose of providing the essential health benefits category of pediatric level oral benefits.
- W. "Service Area" means the collection of counties serviced by a Health

 Benefit Plan. Counties may be grouped into larger aggregations called

 Health Rating Areas and a Health Benefit Plan is required to cover at least
 one Health Rating Area. The aggregation of counties is published in the
 annual bulletin setting forth requirements for ACA submissions.
- X. "Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient, as well as store-and-forward technology and remote patient monitoring.
- Y. "Vision Benefits" means benefits for vision services embedded in, or offered by a rider attached to, a QHP offered through (i) the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.

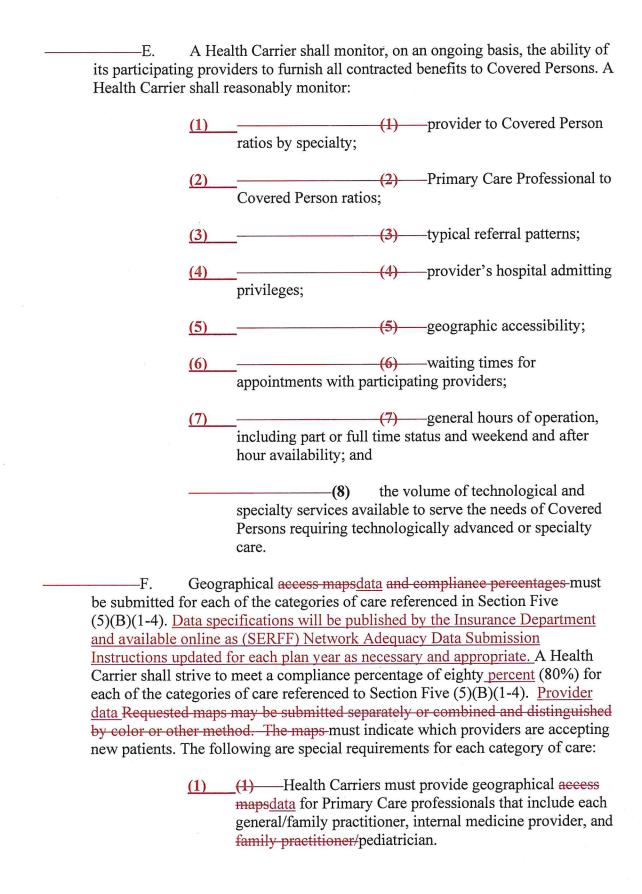
Section 4. Applicability and Scope

This Rule applies to all Health Carriers that offer Health Benefit Plans in this State which are issued or renewed on or after January 1, 2015.

Section 5. Network Adequacy Minimum Standards

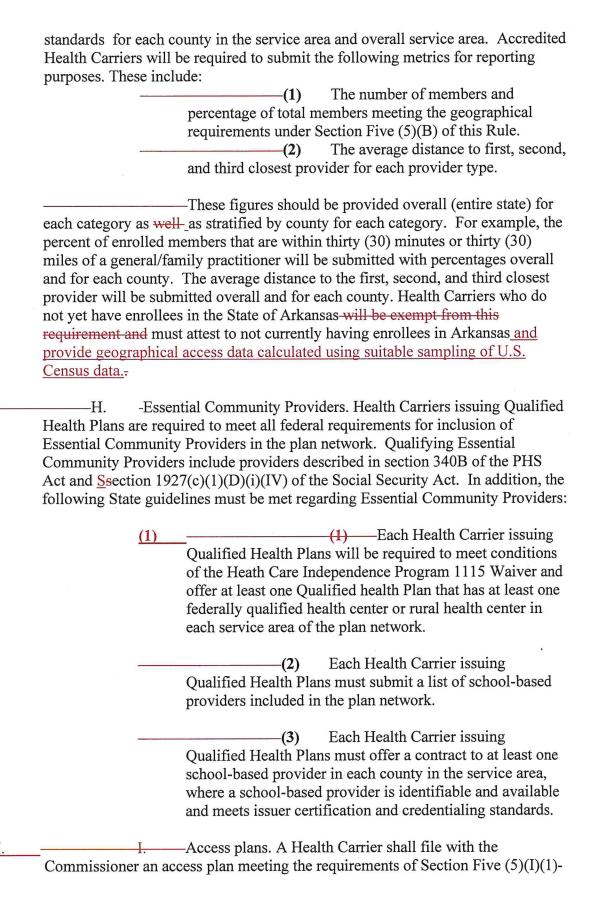
- AA. A Health Carrier providing a Health Benefit Plan shall maintain a network that is sufficient in numbers and types of providers to assure that all Health Care Services to Covered Persons will be accessible without unreasonable delay. Sufficiency may be established by reference to any reasonable criteria used by the Health Carrier and approved by the Commissioner, including but not limited to: provider to Covered Person ratios by specialty; Primary Care Professional to Covered Person ratios; typical referral patterns; provider's hospital admitting privileges; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of Covered Persons requiring technologically advanced or specialty care.
 - B. Every Health Carrier shall strive to meet the following guidelines related to geographic accessibility through geographical data access maps or other

information in format and with content specified by the Department set forth in Section Five (5)(F) below, for the plan year: In the case of Emergency Services, a -(1)Covered Person will have access to Emergency Services, twenty-four (24) hours per day, seven (7) days per week within a thirty (30) mile radius between the location of the Emergency Services and the residence of the Covered Person; In the case of a Primary Care Professional, a (2)Covered Person will have access to covered Primary Care Professional within a thirty (30) mile radius between the location of the Primary Care Professional and the residence of the Covered Person; -(3)In the case of a Specialty Care Professional, a Covered Person will have access to at least one Specialty Care Services within a sixty (60) mile radius between the location of the Specialty Care Professional and the residence of the Covered Person; and For Qualified Health Plans participating in the ACA -(4)approved Marketplace, in the case of Essential Community Providers, a Covered Person will have access to at least one Essential Community Provider within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of the Covered Person. The Health CCarrier shall provide accurate provider practice addresses to the Department. Practice locations should be current at the time of data submission to the Department. In the event that a Health Carrier has an insufficient number or type of participating providers to provide a Covered Benefit, the Health Carrier shall ensure that the covered person obtains the Covered Benefit at no greater cost to the Covered Person than if the benefit were obtained from participating



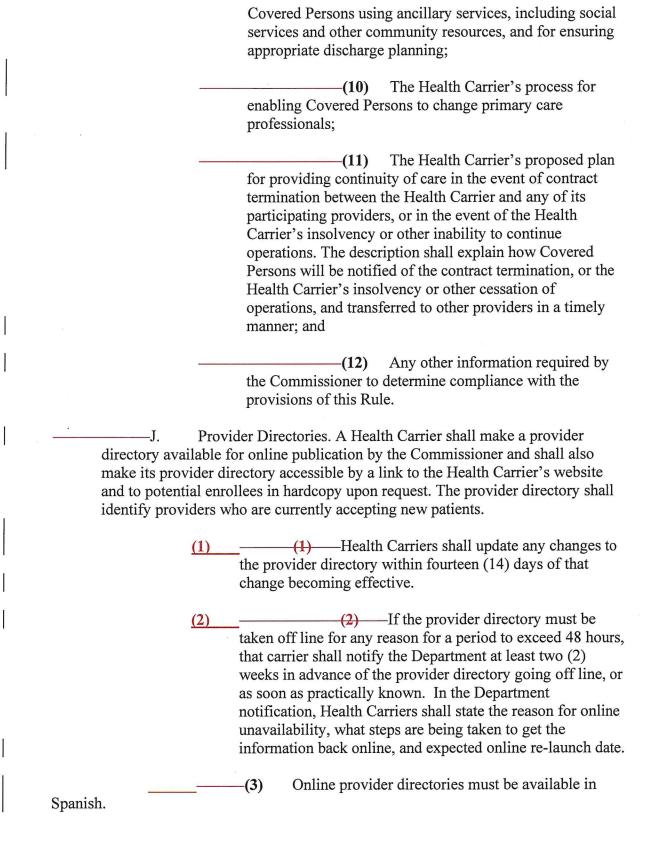
		l access maps for hospitals and Specialty Care sProfessionals according to the following
	(b)	Arkansas hospital licensure type; home health agencies; skilled nursing Facilities (d) all specialty
		care categories and sub-speciality speciality categories covered under the Health Benefit PBlan;
(3)	for mental he	ers must provide geographical access maps <u>data</u> ealth, behavioral health, and substance use tegorized between:
	(b)	and state licensed clinical psychologists; substance use disorder providers; and(c) other mental health,
		behavioral health, and substance use disorder providers with additional documentation describing the provider and facility types included within the other category.
	geographical Providers wi	-Health Carriers seeking certification ACA approved Marketplace must provide access mapsdata for Essential Community th the providers grouped within the following set forth in the ACA and pursuant to CMS
(b) (e) (d) (e) (f)	Ryan White family plann Indian provide hospital; and	ing provider; ler;
limited to school based prov	iders.	
		s: Non-accredited Health Carriers will be rating performance for each of the above

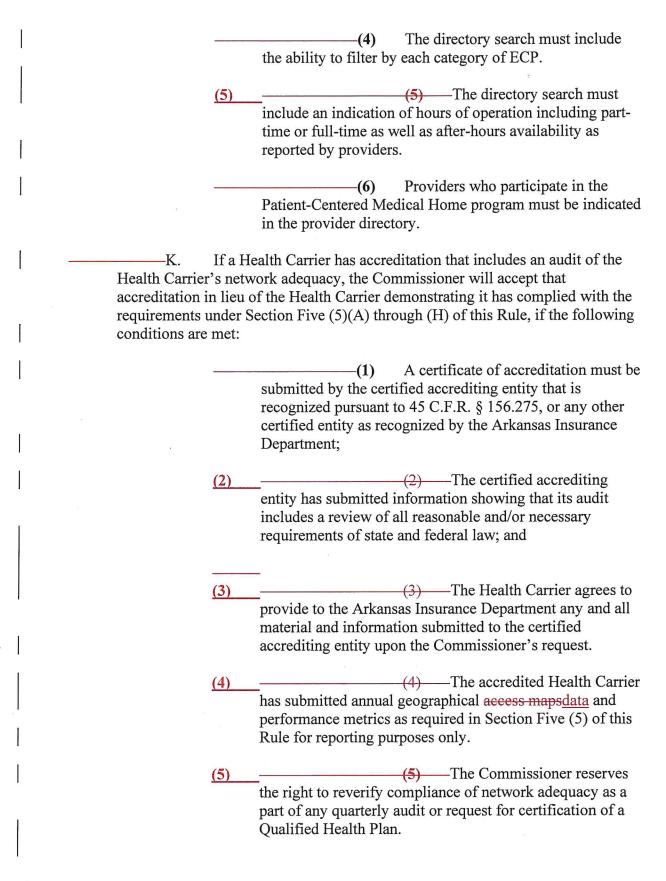
(2) Health Carriers must provide



(12) of this Rule for Health Benefit Plans issued or renewed in this State on or after January 1, 2015. The Health Carrier shall make the access plans, absent proprietary information, available to its insured The Health Carrier shall prepare an access plan prior to offering a new Health Benefit Plan, and shall update an existing access plan whenever it makes any material change to an existing Health Benefit Plan such as the loss of a material provider such as a hospital or multispecialty clinic. The access plan shall describe or contain at least the following:

(1)	The Health Carrier's network;
(2)	——————————————————————————————————————
(3)	(3) The Health Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;
	(4) The Health Carrier's efforts to address the needs of Covered Persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
	(5) The Health Carrier's methods for assessing the health care needs of Covered Persons;
	(6) The Health Carrier's method of informing Covered Persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;
	The Health Carrier's method for assessing consumer satisfaction;
	(8) The Health Carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;
	ensuring the coordination and continuity of care for Covered Persons referred to specialty providers for





- L. The Commissioner will also accept an accreditation of a Health Carrier's access plan by a certified accrediting entity that a Health Carrier has an access plan meeting the requirements of Section Five (5) (I)(1)-(12) of this Rule although such plan must be filed with the Commissioner.
- M. All Time and distance guidelines as set forth in this Rule are minimum standards only.

 The Commissioner, pursuant to his or her discretion, may publish more detailed and specific network adequacy time/distance standards, as well as guidelines regarding the use of telemedicine to meet network adequacy standards, via SERFF Network

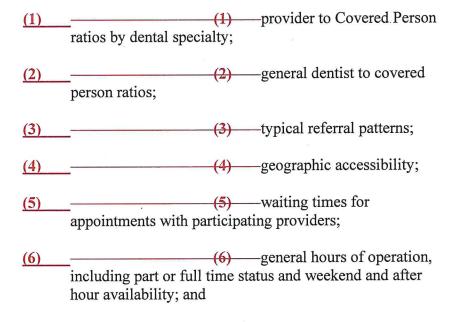
 Adequacy Data Submission Instructions, and/or annual bulletin for setting forth certification requirements for ACA submissions.

Section 6. Stand-alone Dental Plans

- (A₂) For Stand-alone dental plans offered through the ACA approved Marketplace or where a Stand-alone dental plan is offered outside of the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits, all such Stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions. Dental networks for oral services must be sufficient for the enrollee population in the service area based on potential utilization. Networks shall strive to meet the following guidelines through geographical access mapsdata or other information in format and with content specified by the Department, set forth in Section Five (5)(F), above, for the plan year:
 - (1) —In the case of a non-specialist oral care provider, a Covered Person will have access to at least one (1) dentist within a thirty (30) mile radius between the location of the dentist and the residence of the Covered Person;
 - provider, a Covered Person will have access to at least one specialist dentist within a sixty (60) mile radius between the location of the Specialty care professional and the residence of the Covered Person; and
 - health services is located within a thirty (30) mile radius
 between the location of the Essential Community Provider
 and the residence of a covered person, a Stand-alone Dental
 Carrier must make reasonably best efforts to provide the
 covered person access to that Essential Community
 Provider.

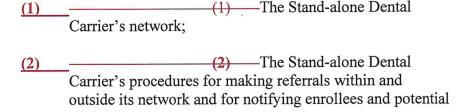
- (4) For purposes of satisfying the requirements of Section Six (6)(A)(1)-(3) of this Rule, a Stand-alone Dental Carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in Section Five (5)(K) of this Rule.
- (5) The Health Carrier shall provide accurate provider practice addresses to the Department. Practice locations should be current at the time of data submission to the Department.
- (3) A Covered Person will have access to at least one Essential Community Provider within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of the Covered Person.
 - For purposes of satisfying the requirements of Section Six (6)(A)(1) (3) of this Rule, a Stand alone dental carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in Section five (5)(K)(1) (5) of this Rule.
- (B.) Stand-alone Dental Carriers applying to the Commissioner to participate in the ACA approved Marketplace or offer a Stand-alone dental plan outside the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits are required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. These figures should be provided overall (entire state) for each category as well as stratified by county for each category. For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general dentist will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. These include:
 - percentage of total members meeting the geographical requirements under Section Six (6)(A) of this Rule.
 - and third closest provider for each provider type.
 - (3) Stand--alone Dental Carriers who do not yet have enrollees in the State of Arkansas will be exempt from this requirement and must attest to not currently having enrollees in Arkansas and provide geographical access data calculated suitable sampling of U.S. Census data.-
- (C.) In the event that a Stand-alone Dental Carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health Carrier shall ensure that the Covered Person obtains the covered benefit at no greater cost to

the Covered Person than if the benefit were obtained from Participating providers, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier including but not limited to:

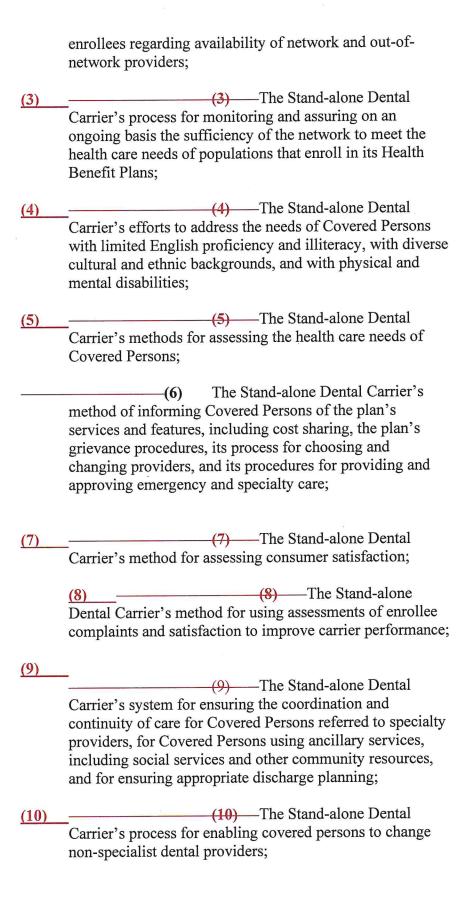


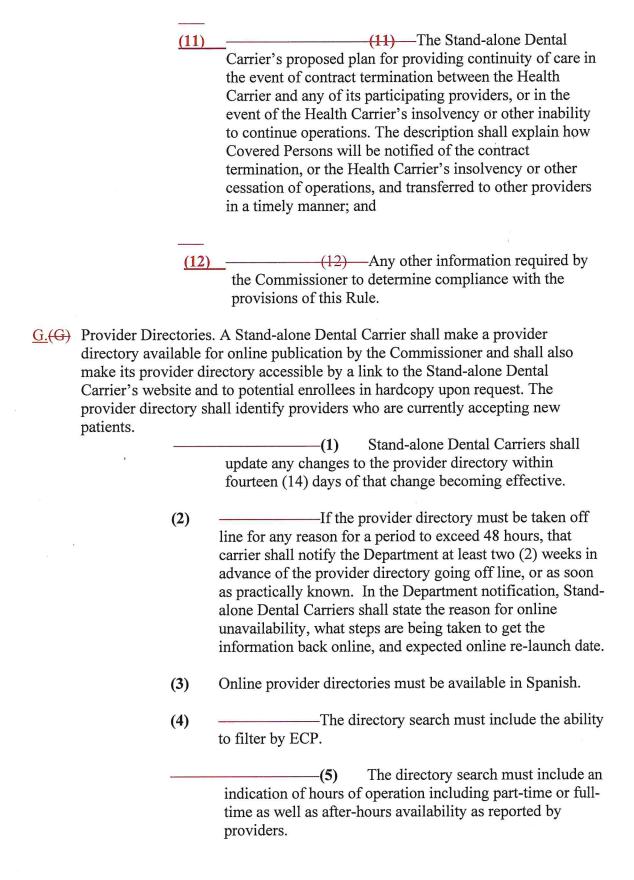
⁽D.) In determining whether a Health Carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of dental providers in the service area under consideration.

F.(F) Access plans. A Stand-alone Dental Carrier shall file with the Commissioner an access plan meeting the requirements of Section Six (6)(F)(1)-(12) of this Rule for Stand-alone dental plans issued or renewed in this State on or after January 1, 2015. The Stand-alone Dental Carrier shall make the access plans, absent proprietary information, available to its insureds. The Stand-alone Dental Carrier shall prepare an access plan prior to offering a new Stand-alone dental plan, and shall update an existing access plan whenever it makes any material change to an existing Stand-alone dental plan such as the loss of a material provider. The access plan shall describe or contain at least the following:



⁽E.) A Stand-alone Dental Carrier shall monitor, on an ongoing basis, the ability of its Participating providers to furnish all contracted benefits to Covered Persons.





Section 7. Provider Type NPI Pool Data Maintenance

- A. A list of provider types developed by the Department and the Arkansas

 Department of Health will be monitored for network adequacy. The providertypes are defined in terms of National Uniform Claim Committee (NUCC)
 taxonomy codes. The provider-type list will be reviewed annually for:
 - (1) Sufficiency. This could be to add provider-types deemed necessary for coverage of health care services most appropriate for Arkansans or to remove provider-types that are no longer appropriate.
 - with the provider-type conveys the intended scope of the provider-type. The taxonomy association with a provider-type definition communicates the actual practice of the provider rather than their academic qualification. For example, a provider qualified as an internal medicine physician cannot be considered a Primary Care Provider if the provider works only in emergency rooms or is only associated with a pain management clinic.
- B. The Department will facilitate a system of on-going industry data maintenance of NPI association(s) with various provider types defined in Section 7(A). This association will be based on the provider's actual practice. This will be done to facilitate a common and uniform understanding of each provider's provider type(s) classification. This NPI association data with provider-types will be referred to as Provider-Type-NPI-Pool (PTNP) data. The process and timelines in the PTNP data maintenance effort will be outlined by the Department on an annual basis through online documentation. This The process will involve two stages of data submission by the carriers. The first stage will involve carriers suggesting changes suggestions of changes to in the PTNP data followed by the second stage when the carriers will vote on the suggestions consolidated from the first stage. The Department will facilitate oversight of the process and may classify a NPI lacking unanimous agreement among carriers.
- C. Participation exemptions. A carrier with fewer than five thousand (5,000) covered individuals as of December 31 of the previous calendar year will not be required to participate in the PTNP data maintenance process. For purposes of determining whether a carrier is subject to the participation requirements of PTNP data maintenance the carrier must aggregate the number of covered individuals for all companies at the Group Code level as defined by the National Association of Insurance Commissioners. Carriers that offer medical, dental, and pharmaceutical benefits, or any combination thereof, under separate or combined plans will count all covered individuals, irrespective of the comprehensiveness of the plan, toward the five thousand (5,000) covered individual threshold.

D.	If a carrier does not believe it meets the definition of a submitting entity herein or
	does not believe it meets the 5,000 covered individuals' threshold, that entity may
	dispute the Commissioner's decision in accordance with the Arkansas
	Administrative Procedure Act.

Section 8. Submission Timeline for Network Adequacy Review

<u>Health Carriers will submit data for network adequacy review according to the timeline contained in the annual certification requirements bulletin.</u>

Section <u>97</u>. Enforcement

The penalties, license actions or orders as authorized under Ark. Code Ann. § 23-66-210 shall apply to violations of this Rule.

Section 10.8. Effective Date

The effective date of this Rule is January 1, 201522.

ALAN MCCLAIN—	JAY BRADFUKD
INSURANCE COMM	IISSIONER
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DATE	